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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/10/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
1 Transforaminal Epidural Steroid Injection at the Right S1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Anesthesiology

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Cover sheet and working documents
Utilization review determination dated 06/25/12, 06/08/12, 10/29/09
Operative report dated 11/19/09, 04/20/09, 09/22/08
Letter dated 11/24/08, 10/15/08
Explanation of review
MRI lumbar spine dated 06/03/02
EMG/NCV dated 04/12/12
Health insurance claim forms
Peer review dated 07/20/10
Appeal letter from patient dated 06/14/12
Office visit note dated 04/23/12

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a male whose date of injury is xx/xx/xx. On this date the patient injured his lower back while working on a machine. MRI of the lumbar spine dated 06/03/02 revealed disc space narrowing at L5-S1 with 6-7 mm posterocentral right paracentral subligamentous herniation extends 8 mm superiorly, mildly indents the sac, deviates and compresses the right S1 nerve root sleeve; there is moderate bilateral foraminal narrowing. Treatment to date includes right lumbar facet injections on 09/22/08, 04/20/09 and 11/19/09. EMG/NCV dated 04/12/12 revealed no electrodiagnostic evidence to indicate lumbosacral radiculopathy. Follow up note dated 04/23/12 indicates that the patient complains of low back pain with radiation down the posterior right leg. Medications include Hydrocodone-ibuprofen, Lyrica, Lidoderm patch and Baclofen. On physical examination gait and station are normal.

Initial request for transforaminal epidural steroid injection at the right S1 was non-certified on 06/08/12 noting that copies of the specialists' analyses for the MRI and EMG/NCV were not available for review. There were no objective clinical findings indicative of radiculopathy such as loss of related reflexes, muscle weakness and/or atrophy of muscle groups in the related myotome, altered sensation in the corresponding dermatome or positive nerve root tension signs. There was no documentation that conservative measures to include oral pharmacologic intervention, physical therapy, and exercise programs have been exhausted prior to this request for injection. The denial was upheld on appeal dated 06/25/12 noting that physical examination findings failed to document radiculopathy. There is no recent physical examination done by the requesting provider to include motor and sensory examinations and reflexes. Moreover, objective documentation of pain relief from conventional treatments such as physical therapy, medications and exercise was not submitted.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Based on the clinical information provided, the request for 1 transforaminal epidural steroid injection at the right S1 is not recommended as medically necessary, and the two previous denials are upheld. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The submitted EMG/NCV dated 04/12/12 revealed no electrodiagnostic evidence to indicate lumbosacral radiculopathy. There is no current, detailed physical examination submitted for review to establish the presence of active lumbar radiculopathy. The submitted physical examination does not include any motor, sensory, reflex or straight leg raising findings and notes only that gait and station are normal. Given the current clinical data, the requested epidural steroid injection is not indicated as medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)